

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0005009</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Sunny Acres Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12-01-01</u> to <u>11-30-02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>R. R. 3</u> <u>Petersburg, Illinois</u> <u>62675</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Menard</u>		Officer or Administrator of Provider	
Telephone Number: <u>217-632-2334</u> Fax # <u>217-632-2774</u>		(Signed) _____ <u>03-31-03</u> (Date)	
IDPA ID Number: <u>37-6005977001</u>		(Type or Print Name) <u>Deanna Wagner</u>	
Date of Initial License for Current Owners: <u>1966</u>		(Title) <u>Assistant Administrator</u>	
Type of Ownership:		Paid Preparer	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Signed) _____ <u>03-31-03</u> (Date)	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Print Name and Title) <u>Michael J. Feriozzi</u> <u>CPA</u>	
<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____		(Firm Name & Address) <u>Michael J. Feriozzi, CPA</u> <u>1316 S. Glenwood Avenue Springfield, Illinois 62704</u>	
In the event there are further questions about this report, please contact: Name: <u>Mrs. Marjorie Moritz</u> Telephone Number: <u>217-632-2334</u>		(Telephone) <u>217-522-8689</u> Fax # <u>217-632-2774</u>	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Sunny Acres Nursing Home# 0005009 Report Period Beginning: 12-01-01 Ending: 11-30-02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>106</u>	Skilled (SNF)	<u>106</u>	<u>38,690</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,695</u>	<u>17,045</u>		<u>33,740</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,695</u>	<u>17,045</u>		<u>33,740</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.21%

D. How many bed-hold days during this year were paid by Public Aid?

42 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1966

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☒Tax Year: n/a Fiscal Year: November 30

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	191,918	23,466	2,065	217,449		217,449		217,449			1
2	Food Purchase		182,498		182,498	(19,352)	163,146	(10,251)	152,895			2
3	Housekeeping	159,644	30,754		190,398		190,398		190,398			3
4	Laundry	35,588	4,178		39,766		39,766		39,766			4
5	Heat and Other Utilities			124,879	124,879		124,879		124,879			5
6	Maintenance	28,646	53,536	2,400	84,582		84,582		84,582			6
7	Other (specify):*											7
8	TOTAL General Services	415,796	294,432	129,344	839,572	(19,352)	820,220	(10,251)	809,969			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,132,562	93,124	129,104	1,354,790		1,354,790	(24,359)	1,330,431			10
10a	Therapy	49,398	2,400	2,343	54,141		54,141		54,141			10a
11	Activities	37,375	1,400	4,868	43,643		43,643		43,643			11
12	Social Services	94,100	1,400	3,864	99,364		99,364		99,364			12
13	Nurse Aide Training		1,500	14,762	16,262		16,262		16,262			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,313,435	99,824	160,941	1,574,200		1,574,200	(24,359)	1,549,841			16
	C. General Administration											
17	Administrative	106,891	3,105	5,907	115,903		115,903	(5,907)	109,996			17
18	Directors Fees											18
19	Professional Services			29,113	29,113		29,113		29,113			19
20	Dues, Fees, Subscriptions & Promotions			20,531	20,531		20,531	(7,404)	13,127			20
21	Clerical & General Office Expenses	39,889	3,105	17,521	60,515		60,515	(1,762)	58,753			21
22	Employee Benefits & Payroll Taxes			265,619	265,619	19,352	284,971		284,971			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,827	3,827		3,827		3,827			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,785	53,785		53,785		53,785			26
27	Other (specify):*											27
28	TOTAL General Administration	146,780	6,210	396,303	549,293	19,352	568,645	(15,073)	553,572			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,876,011	400,466	686,588	2,963,065		2,963,065	(49,683)	2,913,382			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Sunny Acres Nursing Home

#0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,245	52,245		52,245	(52,245)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			52,245	52,245		52,245	(52,245)				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	18,634	583		19,217		19,217	(19,217)				40
41	Coffee and Gift Shops		6,590		6,590		6,590	(6,590)				41
42	Provider Participation Fee		58,035		58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	18,634	65,208		83,842		83,842	(25,807)	58,035			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,894,645	465,674	738,833	3,099,152		3,099,152	(127,735)	2,971,417			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-01

Ending: 11-30-02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,251)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,637)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(44,608)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,907)	17		19
20	Contributions	(254)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,404)	20		28
29	Other-Attach Schedule	(51,674)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (127,735)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (127,735)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sunny Acres Nursing HomeID# 0005009Report Period Beginning: 12-01-01Ending: 11-30-02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	medcial supplies sold to residents	\$ (24,359)	10	1
2	hair care revenues	(19,217)	40	2
3	vending machine sales	(6,590)	41	3
4	other reimbursements	(1,508)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51,674)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,251)	0	0	0	0	0	0	0	0	0	0	(10,251)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,251)	0	0	0	0	0	0	0	0	0	0	(10,251)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(24,359)	0	0	0	0	0	0	0	0	0	0	(24,359)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(24,359)	0	0	0	0	0	0	0	0	0	0	(24,359)	16
	C. General Administration													
17	Administrative	(5,907)	0	0	0	0	0	0	0	0	0	0	(5,907)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,404)	0	0	0	0	0	0	0	0	0	0	(7,404)	20
21	Clerical & General Office Expenses	(1,762)	0	0	0	0	0	0	0	0	0	0	(1,762)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(15,073)	0	0	0	0	0	0	0	0	0	0	(15,073)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,683)	0	0	0	0	0	0	0	0	0	0	(49,683)	29

Summary B

11-30-02

[illegible]

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100	None		Countryside Estates of the County	Petersburg, Illinois	independent living facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-01 Ending: 11-30-02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-01 Ending: 11-30-02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	not applicable				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10	Nursing Home Revenue		x	To partially finance	\$16,348.00	04-28-98	1,550,000	1,020,000	04-28-08	0.0483	52,245	10	
11	Bonds			the construction of an								11	
12				independent living facility								12	
13												13	
14	TOTAL Non-Facility Related				\$16,348.00		\$ 1,550,000	\$ 1,020,000			\$ 52,245	14	
15	TOTALS (line 9+line14)						\$ 1,550,000	\$ 1,020,000			\$ 52,245	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Sunny Acres Nursing Home**# **0005009** Report Period Beginning: **12-01-01** Ending: **11-30-02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ none	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	11	
	2001	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

41,190

B. General Construction Type:

Exterior

brick

Frame

protected noncombust

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Estates of the County is an independent living facility located adjacent to Sunny Acres Nursing Home. The operations of Countryside Estates of the County are accounted for in a separate fund of the County. The operations of Sunny Acres Nursing Home of Menard County are also accounted for in a separate Menard County Fund. Menard County issued revenue bonds in April, 1998 through the Sunny Acres Nursing Home Fund to partially finance the construction of the facility for Countryside Esates of the County. That portion of the construction project not financed with the proceeds of the revenue bond issue was finaced with a contribution from the Sunny Acres Nursing Home Fund in the amount \$1,071,628.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	land that the nursing home is situated on is not		1966	\$ 25,000	1
2	reported as an asset of the Nursing Home				2
3	TOTALS			\$ 25,000	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	58	1966	1966	\$ 526,787	\$ 13,170	40	\$ 13,170	\$	\$ 454,357
5	38	1977	1977	568,714	14,218	40	14,218		355,449
6		1984	1984	61,842	2,061	30	2,061		38,132
7	10	1993	1993	654,160	16,354	40	16,354		149,912
8		1995	1995	68,999	3,450	20	3,450		24,150
Improvement Type**									
9	generator	1980		28,901		10			28,901
10	fire alarm system	1981		9,805		10			9,805
11	none	1982							
12	gazebo and floor coverings	1983		12,750	554	20-25	554		10,805
13	flooring, phone, and paging systems, air conditioners	1984		30,885	719	10-25	719		27,293
14	sun room remodelling and wallpaper	1985		7,061	143	5-30	143		5,422
15	kitchen remodelling, wallpaper, parking lot, nightlight, etc.	1986		36,333	650	5-25	650		33,457
16	boiler repair, sprinkler system, office remodelling, a/c	1987		17,193	330	5-25	330		15,915
17	roof, chimney, carpeting, sprinkler system,	1988		147,826	80	5-25	80		146,613
18	compressor, canopy, carport	1989		6,472	293	15-30	293		3,991
19	asbestos removal, flooring, water heater, landscaping, canopy	1990		28,642	793	5-30	793		16,084
20	main air conditioning unit	1991		5,194	346	15	346		4,009
21	none	1992							
22	new lagoon, tiling, hot water, heater, aviary	1993		223,851	37,834	5-30	37,834		106,737
23	fill old lagoon, flooring, wallpaper, and painting, sign for front	1994		49,671	1,402	5-25	1,402		41,726
24	major boiler repair and remodelling project	1995		10,685	489	5-10	489		9,095
25	special needs unit, resident walking gardens, vinyl soffets	1996		139,517	6,048	5-30	6,048		46,321
26	donor recognition wall, remodelling, draperies, shades	1997		20,798	2,310	5-10	2,310		19,751
27	major boiler repair, air conditioners, ceiling tile replacement	1998		21,699	2,007	10-15	2,007		8,735
28	two commercial water heaters, entrybath, rooftop a/c	1999		41,844	4,747	7-10	4,747		16,615
29	plumbing improvements, structural improvements	2000		18,896	6,299	3	6,299		15,747
30	plumbing, electrical, boiler rehab	2001		22,162	4,432	3-5	4,432		6,648
31	structural improvements, sewer line and walls	2002		77,846	939	10-15	939		939
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,838,533	\$ 119,668		\$ 119,668	\$	\$ 1,596,609	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 384,743	\$ 59,078	\$ 59,078	\$	5-20	\$ 235,140	71
72	Current Year Purchases	23,082	1,575	1,575		5	1,554	72
73	Fully Depreciated Assets	280,945	1,554	1,554		5-20	280,945	73
74								74
75	TOTALS	\$ 688,770	\$ 62,207	\$ 62,207	\$		\$ 517,639	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	facility operations	1993 mercury sable	1994	\$ 12,925	\$	\$	\$	3	\$ 12,925	76
77	facility operations	1989 van	1989	20,735				3	20,735	77
78	facility operations	1989 van overhaul	1993	1,585				3	1,585	78
79										79
80	TOTALS			\$ 35,245	\$	\$	\$		\$ 35,245	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,562,548	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 181,875	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,875	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,149,493	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: not applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER AIDE <u>87</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER AIDE <u>40</u>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 409	\$	\$ 409
2	Books and Supplies	40	80		120
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	262	2,200		2,462
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 302	\$ 2,689	\$	\$ 2,991
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,991			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ none

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	11

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits		4,608	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,807)		229,922	3
4	Supply Inventory (priced at cost)		18,000	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 252,530	\$ 260,271	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		2,243,384	12
13	Land			13
14	Buildings, at Historical Cost		2,838,533	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		724,015	16
17	Accumulated Depreciation (book methods)		(2,149,493)	17
18	Deferred Charges		4,957	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		435,467	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,096,863	\$ 4,089,122	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,349,393	\$ 4,349,393	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,063	\$ 114,363	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		5,700	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,202	107,202	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,135	4,135	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 231,400	\$ 231,400	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,020,000	1,020,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,020,000	\$ 1,020,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,251,400	\$ 1,251,400	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,097,993	\$ 3,097,993	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,349,393	\$ 4,349,393	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,972,750	1
2	Restatements (describe):		2
3	rounding	(2)	3
4	return of excess imrf contributions from the Menard		4
5	County Social Security and Retirement Fund	52,445	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,025,193	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	72,800	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 72,800	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,097,993	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,257,016	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,257,016	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	9,041	12
13	Barber and Beauty Care	19,717	13
14	Non-Patient Meals	10,251	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,508	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,517	23
	D. Non-Operating Revenue		
24	Contributions	1,280	24
25	Interest and Other Investment Income***	55,014	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56,294	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,353,827	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	839,572	31
32	Health Care	1,574,200	32
33	General Administration	549,293	33
	B. Capital Expense		
34	Ownership	234,120	34
	C. Ancillary Expense		
35	Special Cost Centers	25,807	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,281,027	40
41	Income before Income Taxes (line 30 minus line 40)**	72,800	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 72,800	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Sunny Acres Nursing Home of Menard County# ###Report Period Beginning: 12/1/2001Ending: 11/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,120	\$ 49,299	\$ 23.25	1
2	Assistant Director of Nursing	2,080	2,120	37,801	17.83	2
3	Registered Nurses	8,560	8,892	146,790	16.51	3
4	Licensed Practical Nurses	13,019	14,400	220,398	15.31	4
5	Nurse Aides & Orderlies	67,385	74,384	678,274	9.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	1,968	26,854	13.65	9
10	Activity Assistants	1,415	1,450	10,521	7.26	10
11	Social Service Workers	8,056	8,785	94,100	10.71	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,131	32,283	15.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,096	7,796	73,257	9.40	15
16	Dishwashers	12,105	13,303	86,378	6.49	16
17	Maintenance Workers	2,209	2,512	28,646	11.40	17
18	Housekeepers	16,603	18,799	159,644	8.49	18
19	Laundry	4,380	4,935	35,588	7.21	19
20	Administrator	1,872	1,872	49,579	26.48	20
21	Assistant Administrator	1,872	1,872	34,025	18.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,538	3,991	39,889	9.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	3,681	4,156	49,398	11.89	30
31	Medical Records					31
32	Other Health Care(specify)	1,532	1,784	23,287	13.05	32
33	Other(specify)	1,599	1,781	18,634	10.46	33
34	TOTAL (lines 1 - 33)	163,162	179,051	\$ 1,894,645 *	\$ 10.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	59	\$ 2,065	line 1 (3)	35
36	Medical Director	48	6,000	line 9 (3)	36
37	Medical Records Consultant	16	320	line 10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,612	line 10 (3)	39
40	Physical Therapy Consultant	25	2,343	line 10a (3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	70	3,864	line 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	\$ 16,204		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 334	line 10 (3)	50
51	Licensed Practical Nurses	3,512	95,758	line 10 (3)	51
52	Nurse Aides	1,727	32,530	line 10 (3)	52
53	TOTAL (lines 50 - 52)	5,247	\$ 128,622		53

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-01

Ending: 11-30-02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
Marjorie Moritz	administrator	0	\$ 49,579	Workers' Compensation Insurance	\$ 54,227	IDPH License Fee	\$ 150			
Deanna Wagner	assistant administrator	0	34,025	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	13,719			
Diane Willing	quality assurance	0	23,287	FICA Taxes	137,042	Health Care Worker Background Check (Indicate # of checks performed 30)	360			
				Employee Health Insurance	58,578	Dues	6,082			
				Employee Meals	19,352	Miscellaneous fees	220			
				Illinois Municipal Retirement Fund (IMRF)*	15,772					

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

0005009

Report Period Beginning:

12-01-01

Ending:

11-30-02

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. LSN, CONHA \$5,261
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5-15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,911 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES no NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,352 Has any meal income been offset against related costs? yes Indicate the amount. \$ 10,251
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 50%
d. Have vehicle usage logs been maintained? no
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ none
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Michael J. Feriozzi CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. will be completed in April 2003
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

**Sunny Acres Nursing Home of Menard County
#0005009**

Schedule XV, Balance Sheet

Column explanation

The consolidated presentation displays Sunny Acres Nursing Home of Menard County and its investment in Countryside Estates of the County.

Schedule XVII, Income Statement

line 25, interest and investment income

interest income	\$ 9,942
net income of Countryside Estates of the County, the equity method of accounting	45,072
	<hr/>
	<u><u>\$ 55,014</u></u>